

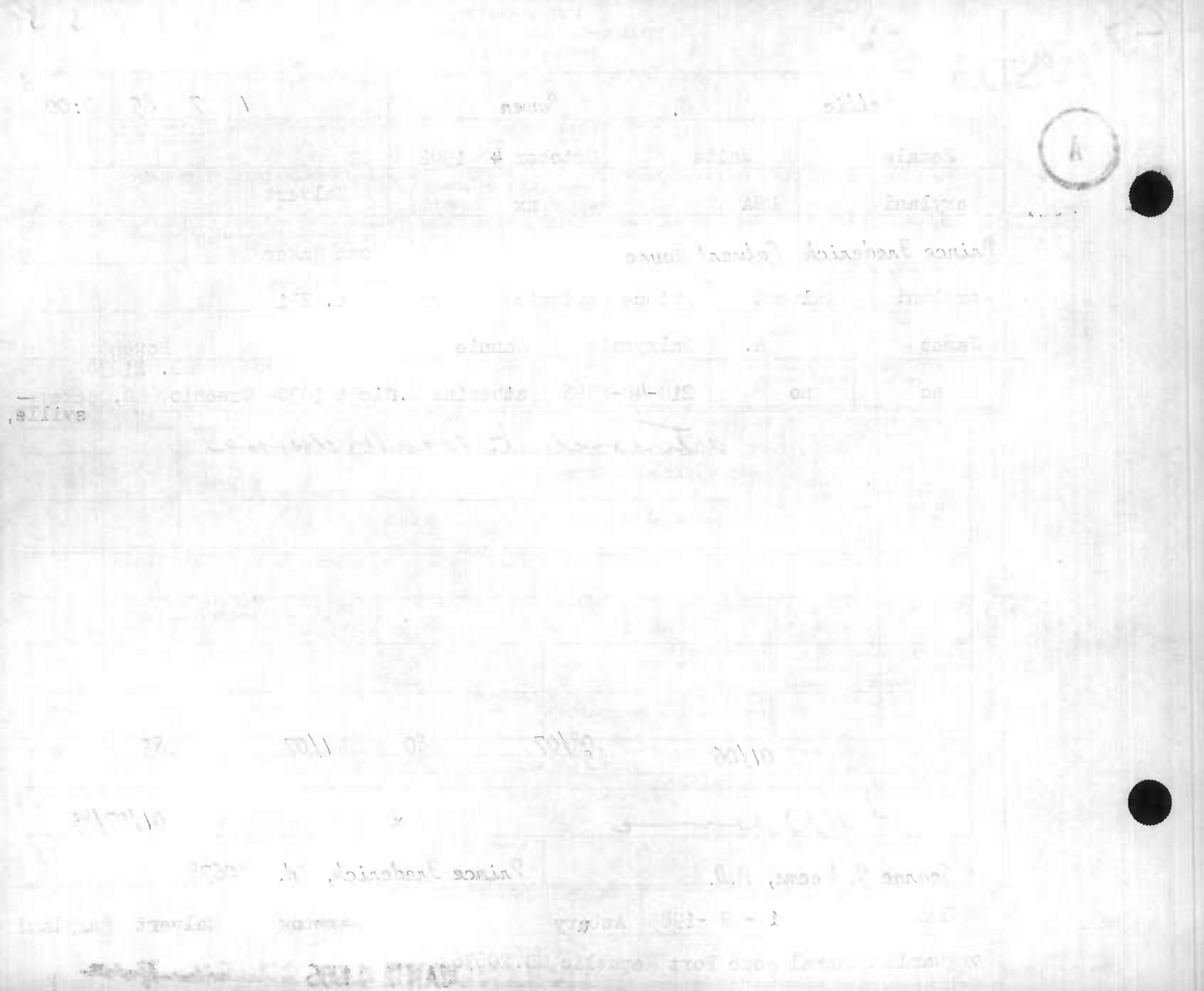
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501735	
										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A		
Nellie M. Bowen						1 7 85			2:00 PM		
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White			October 4 1902			82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA						Calvert		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Prince Frederick			Calvert House			Home Maker					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Calvert			Prince Frederick			NO <input type="checkbox"/>		
13e. STREET ADDRESS						13f. STREET ADDRESS					
						Rt. 231			20678		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
James A. Dalrypmple			Nannie Bowen			214-48-8356			Katherine B. Nicht 10304 Greentop RD, Cockeysville, MD. 21030		
18. CAUSE OF DEATH (Enter only one cause per line for part 1a, and 1c) PART 1. DEATH WAS CAUSED BY			19. APPROXIMATE NUMBER OF DAYS BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) arteriosclerotic vascular disease											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) <input type="checkbox"/> deceased from 07/06 80 to 07/07 80, 19 80, to 19 85, that (1) (we) last saw the deceased alive on 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
George J. Weems, M.D.									01/07/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. ADDRESS			22g. ADDRESS		
George J. Weems, M.D.						Prince Frederick, Md. 20678					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
BURIAL			1 - 9 - 1985			Asbury			Barstow		
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Borgwardt Funeral Home Port Republic MD. 20676						JAN 4 1985					
NAME			ADDRESS								



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicare claim must be postponed.

MEDICAL CERTIFICATION

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8501736

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
NELLIE WILSON BOWEN				JANUARY 24 1985				9:45 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE	WHITE	MONTH	DAY	YEAR	MONTHS	YEARS	MONTHS	YEARS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	USA				CALVERT Co.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
PRINCE FREDERICK	CALVERT MEMORIAL Hospital				Housewife			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md	CALVERT	Huntingtown	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	BOX 36 20639			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	16. KIND OF BUSINESS OR INDUSTRY	
James	Robert	Hance		SARAH	Edith	GRANFORD	LAW	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT	ADDRESS P.O. BOX 36				
NO	217-36-6865		Carl Bowen	Huntingtown Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction								
DUE TO, OR AS A CONSEQUENCE OF (b) CSD.								
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/24 1985 to 1/24 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Kiumarce Yazdani								
22c. DEGREE								
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kiumarce Yazdani								
22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial Jan 27, 1985	23c. NAME OF CEMETERY OR CREMATORIAL CAVITY Cemetery	23d. LOCATION CITY OR TOWN Huntingtown	COUNTY	STATE			
24. FUNERAL DIRECTOR NAME John O. Rausch	ADDRESS Owings Md	25a. DATE REC'D. BY REGISTRAR JAN 28 1985						
				25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall				

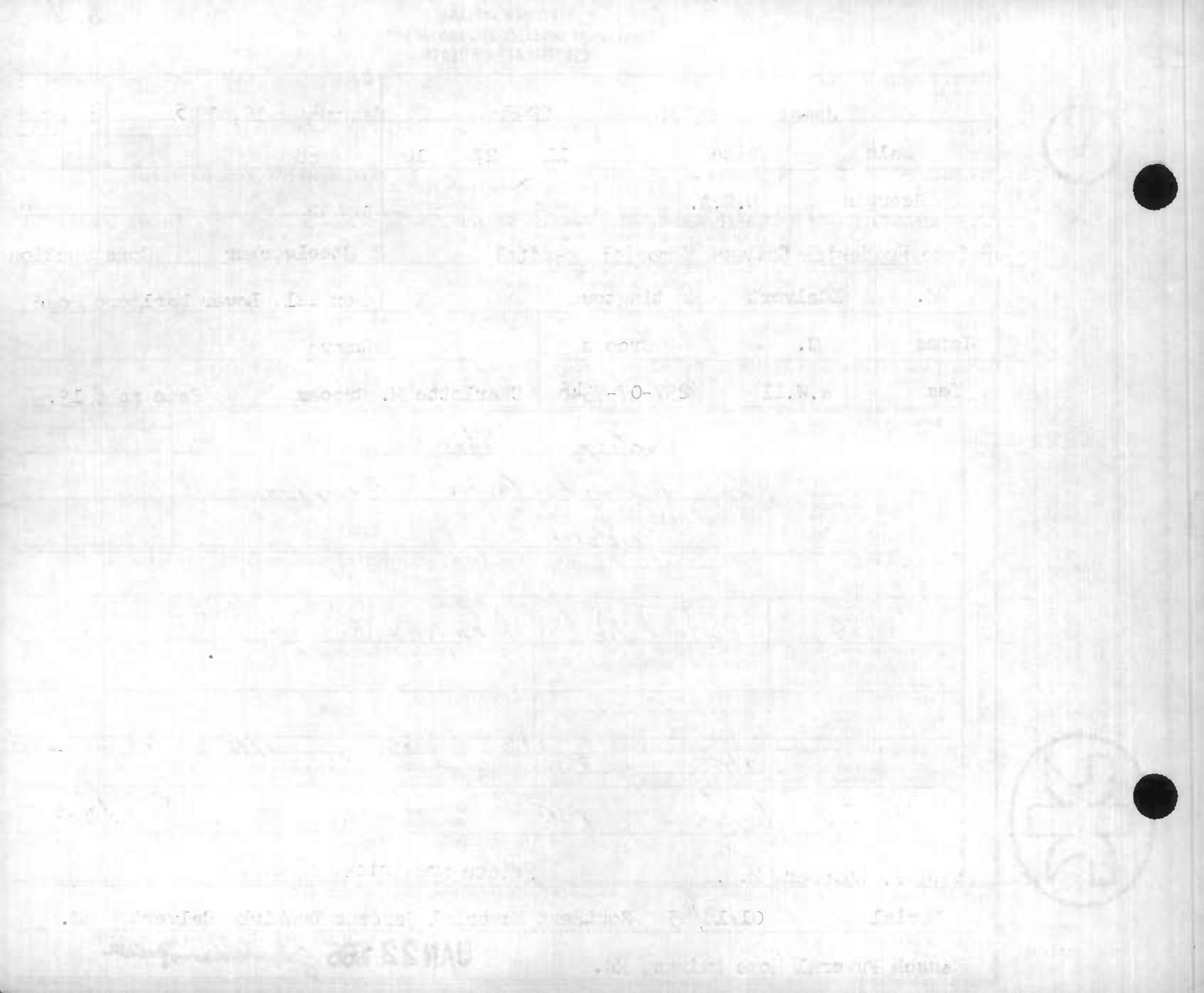
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

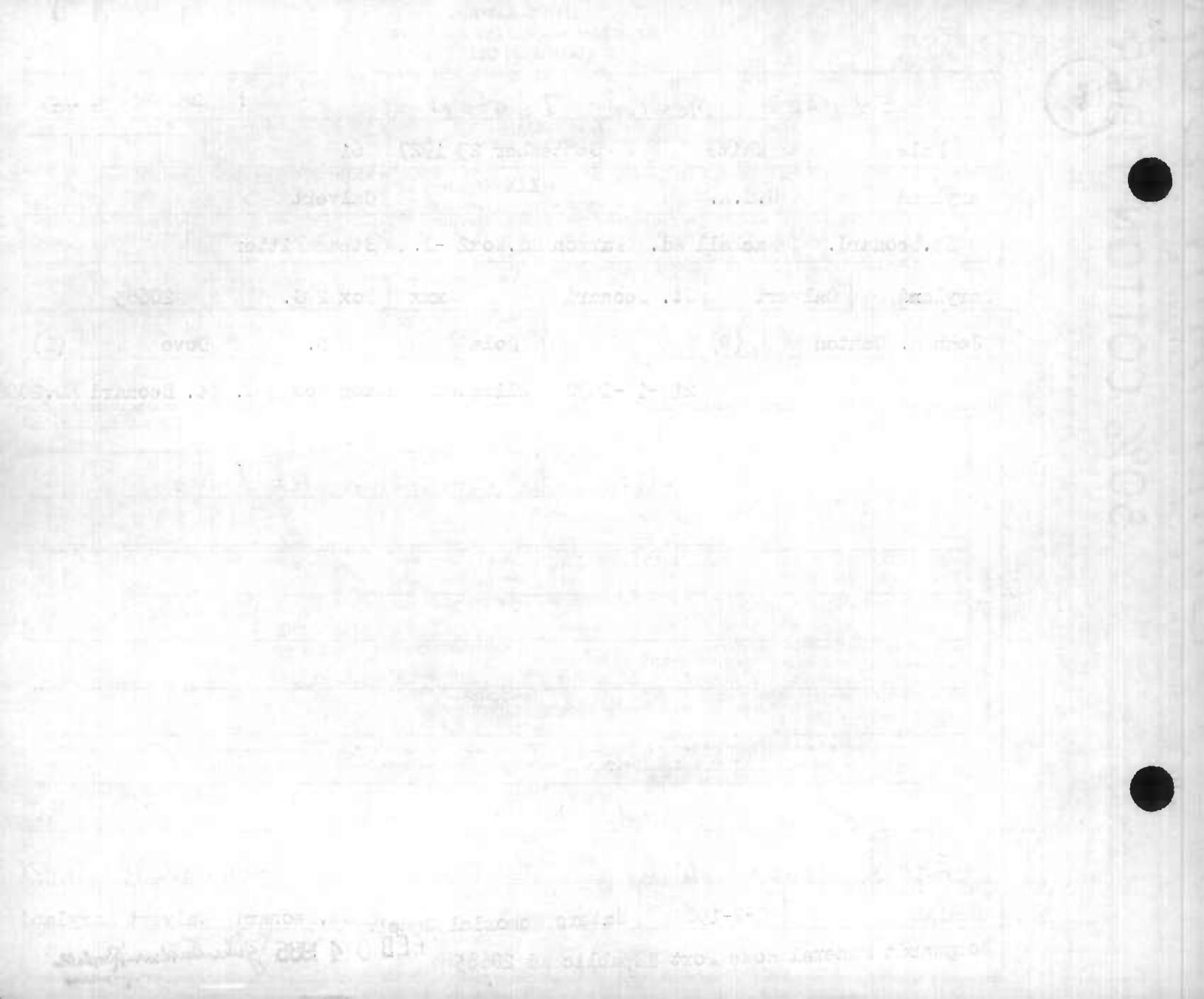
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 7 3 7			
1 - STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
James	Calvin	Crooms		January	16	1985				8:30 p.m.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 27 YEAR 16			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE COUNTRY Georgia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert			MD.					
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker			12b. KIND OF BUSINESS OR INDUSTRY Construction			20634					
13a. STATE Md.	13b. COUNTY X Calvert	13c. CITY OR TOWN Huntingtown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Box 221, Lower Marlboro Road							
14. FATHER'S NAME FIRST James	MIDDLE C.	LAST Crooms	15. MOTHER'S MAIDEN NAME FIRST Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/>	16b. SOCIAL SECURITY NO W.W.II	17. INFORMANT Charlotte M. Crooms	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured Aortic Aneurysm</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acidosis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION 1/16/85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured Aortic Aneurysm</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>1/16</u> 19 <u>85</u> , to <u>1/16</u> 19 <u>85</u> , that (I) <u>did not</u> last saw the deceased alive on <u>1/16</u> 19 <u>85</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.													
22b. SIGNATURE <u>Mark J. Kushner</u> MD										22c. DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED 1/16/85	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Mark J. Kushner, M.D.										22f. ADDRESS Prince Frederick, MD 20678			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 01/18/85	23c. NAME OF CEMETERY OR CREMATORIAL Southern Memorial Gardens	23d. LOCATION CITY OR TOWN Dunkirk	23e. COUNTY Calvert	23f. STATE Md.								
24. FUNERAL DIRECTOR NAME Rausch Funeral Home Owings, Md.	25a. DATE REC'D. BY REGISTRAR JAN 22 1985			25b. REGISTRAR'S SIGNATURE <u>J. Henderson Pendell</u>									
BP													
DHMH - 16 50M 4/82 (VRA 15, 4)													



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IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical certificate must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 7 3 8			
1 - FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Edward Merton Denton						1 29 85			3:45 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
Male		White		September 23 1923			61						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert			MD.	
10. CITY OR TOWN OF DEATH St. Leonard.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mackall Rd. & Parron Rd. Box 2 G.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steam Fitter			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Calvert			13c. CITY OR TOWN St. Leonard			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Box 2 G. 20685	
14. FATHER'S NAME John H. Denton			15. MOTHER'S MAIDEN NAME Nola B. Dove									LAST (L)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 215-18-1830			17. INFORMANT Elizabeth Denton Box 2 G. St. Leonard MD. 20685			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF Metastatic Carcinoma Rt. lung.										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)										
			(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-23-1985, to 19, that (I) (we) last saw the deceased alive on 1-23-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.													
22b. SIGNATURE Zahie Yousaf			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-30-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Zahie Yousaf, M.D.			22e. ADDRESS P.O. Box E Prince Frederick, Md. 20678										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-2-1985			23c. NAME OF CEMETERY OR CREMATORIAL Waters Memorial Cemetery			23d. LOCATION CITY OR TOWN St. Leonard Calvert Maryland			23e. DATE FILED BY REGISTRAR FEB 04 1985	
24. FUNERAL DIRECTOR Borgwardt Funeral Home Port Republic Md 20685			ADDRESS REPUBLIC MD 20685									25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell	

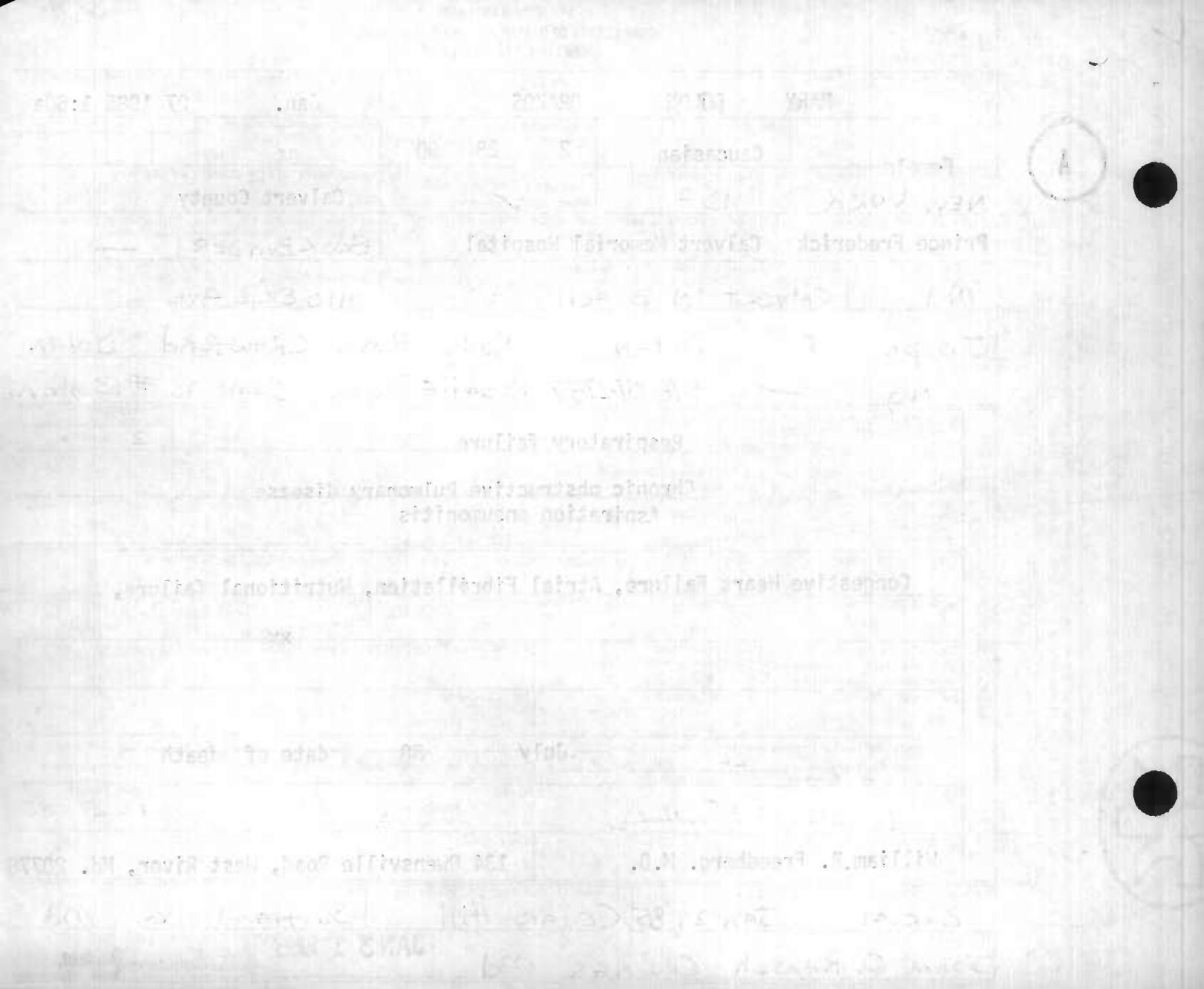


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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8501739											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		
MARY DOLAN DRAKOS			Jan. 27 1985			2b. HOUR					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			Caucasian			2 28 90			94 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
NEW YORK			USA						Calvert County		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Prince Frederick			Calvert Memorial Hospital			BOOKBINDER					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Calvert			N. Beach			13e. STREET ADDRESS 9110 ERIE AVE 20714		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Joseph F DOLAN			Mary Rose CRAWFORD DOLAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			578-07-2757			Rosalie Russell SAME AS #13 ABOVE			2 weeks		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive Pulmonary disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration pneumonitis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
Congestive Heart Failure, Atrial Fibrillation, Nutritional failure.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 26 JUN 1985 to 19 80, to date of death, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William B. Freedberg			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-27-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Freedberg, M.D.			22e. ADDRESS 134 Owensville Road, West River, Md. 20778								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN 29 '85			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill			23d. LOCATION CITY OR TOWN Saultland COUNTY PG. STATE Md		
24. FUNERAL DIRECTOR NAME John O. Rausch OWINGS Md			ADDRESS			25. DATE REC'D. BY REGISTRAR JAN 31 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Freedberg		

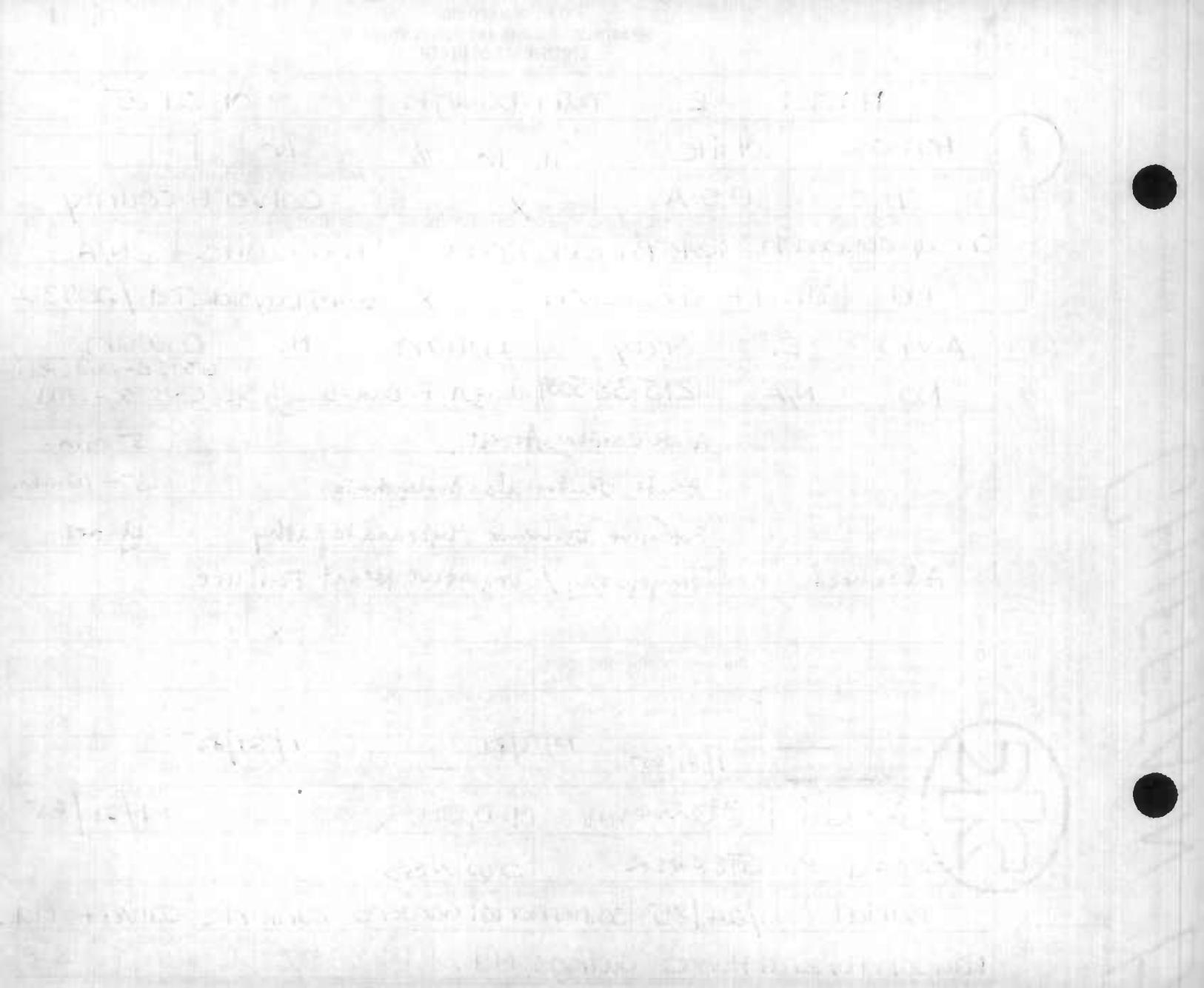


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-in-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8501740		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Hazel			E.	Durnbaugh		01	21	85			M			
SEX		4. RACE	5. DATE OF BIRTH			6. AGE, (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR					
female		white	MONTH 11 DAY 16 YEAR 88			76			IF UNDER 24 HRS	IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
D.C.		U.S.A.						Calvert County			MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Chesapeake Beach		6345 Bayside Road			housewife			N/A						
13a. STATE		13a. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md.		Calvert		Ches. Beach		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6345 Bayside Rd. / 20732						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST					
Alvin		E.	Gray		Lillian		M.	Cowan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		N/A 215-38-5039			William F. Durnbaugh Sr. CHES. B.C.H. MD.		6345 Bayside Rd.			5 min.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Ventricular Arrhythmia</u>												5-10 min.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Extensive Ischemic Myocardopathy</u>												years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Advanced cardiomyopathy / Congestive Heart Failure														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <u>12/16/82</u> 19_____, to <u>1/21/85</u> 19_____, that (I) (we) last saw the deceased alive on <u>1/21/85</u> 19_____, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.														
22b. SIGNATURE <u>Gerald P. Stern</u>		22c. DEGREE M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/21/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gerald P. STERN</u>		22e. ADDRESS Owings												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/24/85		23c. NAME OF CEMETERY OR CREMATORIAL SO. Memorial Gardens			23d. LOCATION Dunkirk		CITY OR TOWN Calvert					
24. FUNERAL DIRECTOR NAME Rausch Funeral Home		ADDRESS Owings, Md.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JAN 28 1985 John Davidson Pendell							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "Harm 8" (harm, any injury, or other traumatic event), the medical certifying physician must initial the line.

F
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8501741

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Janet			Dunsmore Goodwin			January	17	1985		M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Female		White		March 10 1893		92						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH CALVERT				
SCOTLAND		UAS		<input checked="" type="checkbox"/>		<input type="checkbox"/>		MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Prince Frederick		Calvert Nursing Center										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 4. 20678				
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Prince Frederick		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 4. 20678				
14. FATHER'S NAME FIRST John Dunsmore		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE	LAST Craig					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. SOCIAL SECURITY NO. 104-07-1469		17. INFORMANT		ADDRESS				
no		no				Margarite Geiger		Broomes Island Maryland				
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b, AND 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a)						Anterosclerotic coronary artery disease						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause (1b).												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) (this hospital) attended the deceased from 1981 to Jan 16, 1985, that (1) (we) last saw the deceased alive on Jan 15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Charles Bennett M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/17/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Bennett M.D.		22e. ADDRESS P.O. Box 550 Lurby, Md. 20657										
23a. BURIAL, CREMATION, REMOVAL SPECIFY Cremation		23b. DATE 1-18 1985		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria		COUNTY			STATE Virginia	
24. FUNERAL DIRECTOR Borgwardt Funeral Home Port Republic Maryland		ADDRESS JAN 3 0155		25. DATED AND SIGNED BY REGISTRAR/REGISTRAR'S SIGNATURE Julia Kaidan								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

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C

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501742								
1 - STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		Mary								Gutmann		1		9	85	4:30		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?				9. BALTIMORE CITY OR COUNTY OF DEATH		
Female		WHITE		MONTH 5 DAY 29 1890				94		OHIO		USA				CALVERT		
WIDOWED		MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE		13b. COUNTY		14. CITY OR TOWN		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		
Maryland		Calvert		St. Leonard		Calvert House				NO		578-56-8652		Theresa Wells		Arteriosclerosis Var disease		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME FIRST		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		ADDRESS				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 580 Flag Harbor Blvd. 20685		O'Farrell		Sabina		Kenny						St. Leonard				
16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																		
18. CAUSE OF DEATH PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET		21e. CITY OR TOWN		21f. COUNTY		21g. STATE						
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21j. 11/19 84		21k. 01/09		21l. 19 85		21m. 19 85		21n. 19 85						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 01/09 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		22b. SIGNATURE Theresa Wells		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR		22f. STAFF PHYSICIAN		22g. DATE SIGNED 01/09/85						
22h. PHYSICIAN'S NAME (TYPE OR PRINT) George J. Weems, M.D.		22i. ADDRESS Prince Frederick, Md. 20678																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-12-1985		23c. NAME OF CEMETERY OR CREMATORIAL Our Lay Star of The Sea Solomons		23d. LOCATION CITY OR TOWN Calvert		23e. COUNTY MD.		23f. STATE								
24. FUNERAL DIRECTOR BORNARDI FUNERAL HOME Port Republic MARYLAND		25a. DATE REC'D. BY REGISTRAR JAN 2 3 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Ronan														

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THE CHAOS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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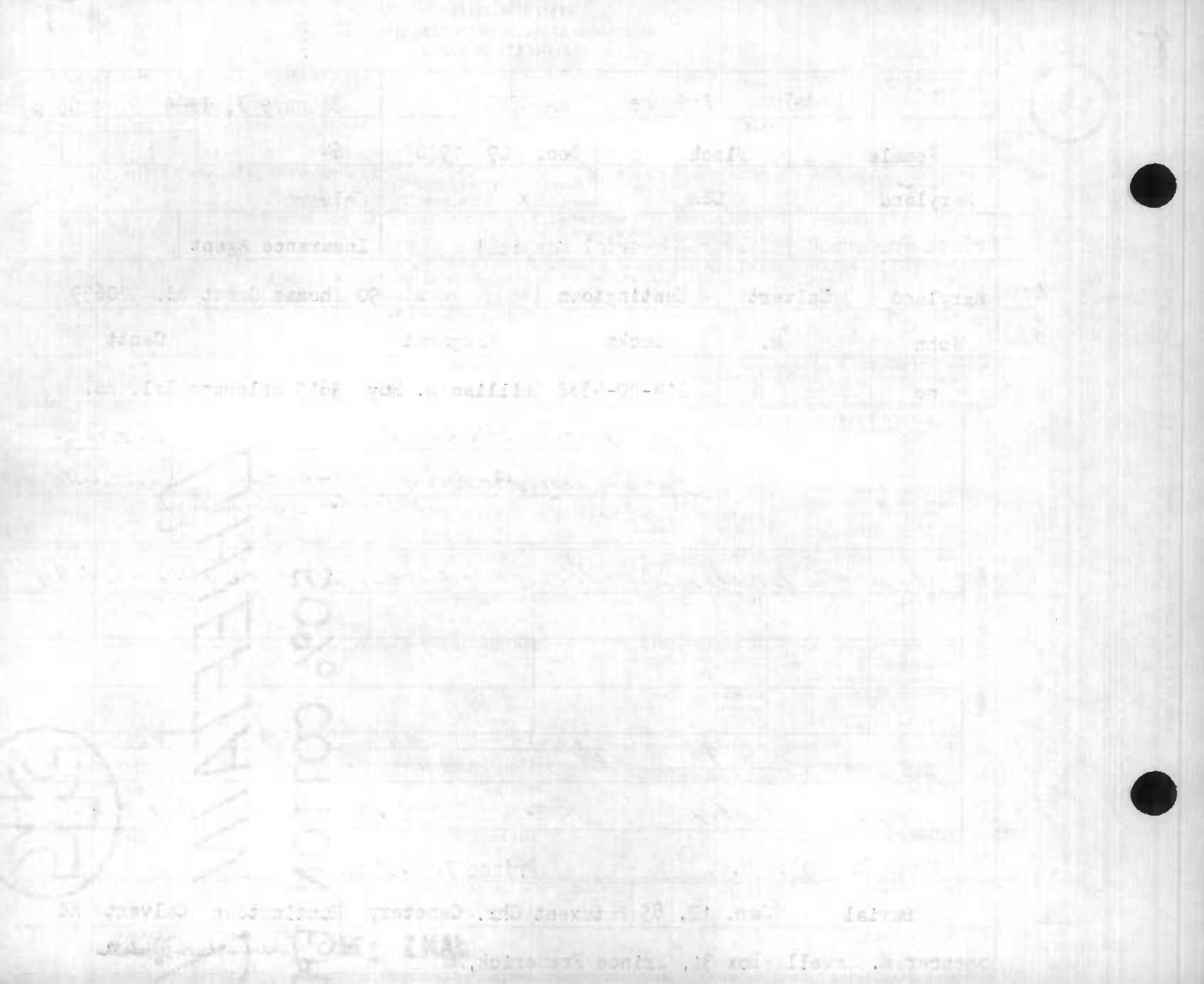
MEDICAL CERTIFICATION

File G606 item 2a
1 - STATE REGISTRAR 8/20/85 rjaSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 7 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Madelyn Arizona HAMMOND						January 7, 1984			1985	4:05 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Black		Dec. 09 1920		64					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		USA						Calvert			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Prince Frederick		Calvert Memorial Hospital		Insurance Agent							
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Calvert	Huntingtown			90 Thomas Gantt Rd. 20639					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
John		H.	Locks	Margaret			Gantt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
no		214-20-4332		Lillian R. Roy		3615 Solomons Isl. Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIOAC ARREST						0-2 wk.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease c DUE TO, OR AS A CONSEQUENCE OF (c) possible embolism						0-2 wk.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Hypoxia Brain Death 20 above, D.M. Peripheral V.G.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-25-1984 to 1-7-1985, that (I) (we) last saw the deceased alive on 1-7-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Mahesh P. Shah, M.D.		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-7-85.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Mahesh P. Shah., M.D.		Prince Frederick, MD 20678									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		STATE				
Burial		Jan. 12, 85	Patuxent Chr. Cemetery		Huntingtown		Calvert	Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D BY REGISTRAR		25. REGISTRAR'S SIGNATURE					
Spencer E. Sewell		Box 31, Prince Frederick, MD		JAN 1 1985		John Anderson, R.R. 1					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 01744

1-
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR	
		Henry	Jackson	HARDY Sr.	Jan. 14	1985			11:20 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.					
Male	White	2 19 1926	58							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		U.S.A.				Calvert			MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Prince Frederick		Calvert Memorial Hospital			Home Improvement			Own Business		
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Prince Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS P.O. Box 817 20678			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST						
David		A.	Hardy	Ida					Bowman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
Yes		W.W.II		230-20-5074		Ineva Hardy (Wife)			Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Emad Al-Banna, M.D.</i>										TITLE (SPECIFY) <i>Medical Examiner</i>
EXAMINER'S NAME (TYPE OR PRINT) <i>Emad Al-Banna, M.D.</i>										ADDRESS <i>Prince Frederick, MD 20678</i>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 1/17/85		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G.	STATE Maryland	
24a. FUNERAL DIRECTOR NAME <i>Frank Gasch's Sons Funeral Home, P.A.</i>		24b. ADDRESS 4739 Baltimore Ave. Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR JAN 16 1985		25b. REGISTRAR'S SIGNATURE <i>Davidson Pendle</i>				

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 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.									
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		5	0	1	7	4	5
		Earl									Harrod, Jr.			<input checked="" type="checkbox"/>		MONTH	DAY	YEAR	2b. HOUR		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY			7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		1		14	19	85	M
Male		Negro		June 9 1942			42 yrs.			MONTH	MONTH	HOURS	MIN	<input checked="" type="checkbox"/>		MONTH	DAY	YEAR	2d. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			Calvert County, MD.				
Maryland		USA																			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Prince Frederick		Calvert Memorial Hospital										Labor									
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Pr. Frederick			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Box 12 Mason Rd. 20678											
14. FATHER'S NAME Earl		MIDDLE			LAST Harrod, Sr.			15. MOTHER'S MAIDEN NAME Gladys			LAST Keemer										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-42-4579			17. INFORMANT Mary Frances Harrod			ADDRESS Box 12 Mason Rd.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). 19a. DATE OF OPERATION																19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			20. AUTOPSY? BODY <input checked="" type="checkbox"/> ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE									
22a. I certify that I had charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					Autopsy <input checked="" type="checkbox"/>			Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
ACTUAL SIGNATURE <i>Thomas D. Smith</i>					TITLE (SPECIFY) M.D. Acting Chief			MEDICAL EXAMINER		DATE SIGNED		1/15/85									
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.			ADDRESS			111 Penn St. Balto. MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 19-85			23c. NAME OF CEMETERY OR CREMATORIAL Carroll Western Cemetery			23d. LOCATION CITY OR TOWN Barstow			COUNTY Calvert		STATE Md								
24. FUNERAL DIRECTOR NAME Spencer E. Sewell		ADDRESS Box 31, Prince Frederick, Md.			25a. DATE REC'D. BY REGISTRAR JAN 17 1985			25b. REGISTRAR'S SIGNATURE <i>Susan Davidson-Pondale</i>													
20M 4/82																					
DHMH - 17 (VR A15 ME (5))																					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 7 4 6					
1 - STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Scottrosa Victoria HAWKINS								January 2, 1985					7:49 PM		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Calvert		MONTHS		DAYS			
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Lusby		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 254, Olivet Rd. 20657							
14. FATHER'S NAME FIRST Thomas		MIDDLE I.		LAST Weems		15. MOTHER'S MAIDEN NAME FIRST Elnora		MIDDLE		LAST Elsey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-30-3115		17. INFORMANT Patricia Buck		ADDRESS P.O. Box 146 Lusby, Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive cerebrovascular accident</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CAD</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Angina pectoris</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														22c. DATE SIGNED 1-3-85	
22b. SIGNATURE <u>Kioumarce Yazdani</u>		22c. DEGREE <u>Yazdani</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kioumarce Yazdani, M.D.		22e. ADDRESS Huntingtown, Maryland 20639													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 7, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Eastern Chapel Cem.		23d. LOCATION CITY OR TOWN Lusby		CITY OR TOWN Calvert		COUNTY		STATE Md			
24. FUNERAL DIRECTOR NAME Spencer E. Sewell		ADDRESS Box 31, Prince Frederick, Md.		25a. DATE REC'D. BY REGISTRAR Jan. 7, 1985		25b. REGISTRAR'S SIGNATURE <u>J. E. Sewell</u>									

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Food

varied, nutritious, balanced

events

enough

needed

Health and well-being

Health and well-being

Health and well-being



BOX
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 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARSHALD, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 01747								
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST RONALD			MIDDLE G.			LAST HENSLEY			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 1-20-85 19		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH April			YEAR 1970			6. AGE (IN YEARS LAST BIRTHDAY) 14 yrs.			7. IF UNDER 1 YR. MONTHS		8. IF UNDER 24 HRS. DAYS		9. DATE PRONOUNCED DEAD 1-20-85 19		10. MONTH DAY YEAR 3:45P M	
10a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10b. CITIZEN OF WHAT COUNTRY? USA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvary Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student			12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Port Republic			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Kenwood Beach Rd. 20676										
14. FATHER'S NAME FIRST Ellis		MIDDLE M.		LAST Hensley			15. MOTHER'S MAIDEN NAME FIRST Bessie			MIDDLE .			LAST Maggard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NO		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR 3:05PM MONTH 1-20-85 YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian riding a sleigh struck by a vehicle														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET Kenwood Branch Rd. CITY Port Republic, COUNTY Maryland STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 1-21-85								
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			M.D.			TITLE (SPECIFY) Assistant MEDICAL EXAMINER 111 Penn Street			ADDRESS											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-24-1985			23c. NAME OF CEMETERY OR CREMATORIAL Christ Church			23d. LOCATION CITY OR TOWN Port Republic COUNTY Calvert STATE MD.								
24. FUNERAL DIRECTOR BORGWARDT FUNERAL HOME ADDRESS PORT REPUBLIC MARYLAND 20676			25a. DATE REC'D. BY REGISTRAR JAN 3 1985						25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Pender</i>											
BP			DHMH - 17 (VR A15 ME (5))																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial certificate. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene, Prison No. Bureau, Cremation, or Removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501748							
										REG. NO.							
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		MONTH	DAY	YEAR	2:30 M				
Ignatious McManus Mayhew										1	20	85	A				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Male			White			MONTH DAY YEAR			72 YRS.			IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MONTH DAYS HOURS MIN.								
Md.			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Prince Frederick			calvert house			farmer			farming								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md.			Calvert			Bunsterland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1, Box 287A/20689					
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST			LAST					
William			Mayhew			Nattie											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			N/A			212-62-0553			Mary P. Mayhew			same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for item 18 and in PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerosis/Var disease</u>																	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b)																	
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION (STATE)		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (the hospital) attended the deceased from 11/19 85 to 11/22 85			22b. to 11/20 85						22c. that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.								
22d. SIGNATURE <u>George J. Weems, M.D.</u>			22e. DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED 1/20/85						
23a. PHYSICIAN'S NAME (TYPE OR PRINT)			23b. ADDRESS						23c. NAME OF CEMETERY OR CREMATORIAL IMMEDIATE CAUSE						23d. LOCATION CITY OR TOWN		
George J. Weems, M.D.			Prince Frederick, Md. 20678						Epiphany Cemetery						Forrestville P.O. MD.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE								
Rausch Funeral Home			1/23/85						JAN 28 1985						John Dawson-Rausch		
BP			ADDRESS														
DHMH - 16 50M 1/1/B1 (VRA 15, 4)																	

DC: 2005-1

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 01749

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

2. FIRST

MIDDLE

LAST

REG. NO.

3. SEX

4. RACE

5. DATE OF BIRTH
MONTH DAY YEAR

6. AGE (IN YEARS
LAST BIRTHDAY)

7. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

8. CITIZEN OF WHAT COUNTRY?

9. MARRIED
WIDOWED

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

13. STATE

14. FATHER'S NAME
FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME
FIRST

MIDDLE

LAST

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YEAR OR UNKNOWN)

17. SOCIAL SECURITY NO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

death resulted from:

Natural causes

Accident

Suicide

Homicide

Undetermined manner

Autopsy

Inspection

Inquiry

and in my opinion

ACTUAL
SIGNATURE

Emad R. Al-Banna, M.D.

M.D.

CEDAR BLUFF

ANNAPOLIS

AD MD

DATE
SIGNED

1/3/1985

EXAMINER'S NAME
(TYPE OR PRINT)

ADDRESS

PRINCE FREDERICK, MARYLAND 2067

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Burial Jan. 8 1985 Cedar Bluff Annapolis AD MD

24. FUNERAL DIRECTOR
NAME

ADDRESS

Taylor Funeral Chapel-Annapolis, MD

25a. DATE REC'D. BY REGISTRAR

JAN 9 1985

25b. REGISTRAR'S SIGNATURE

Emad R. Al-Banna

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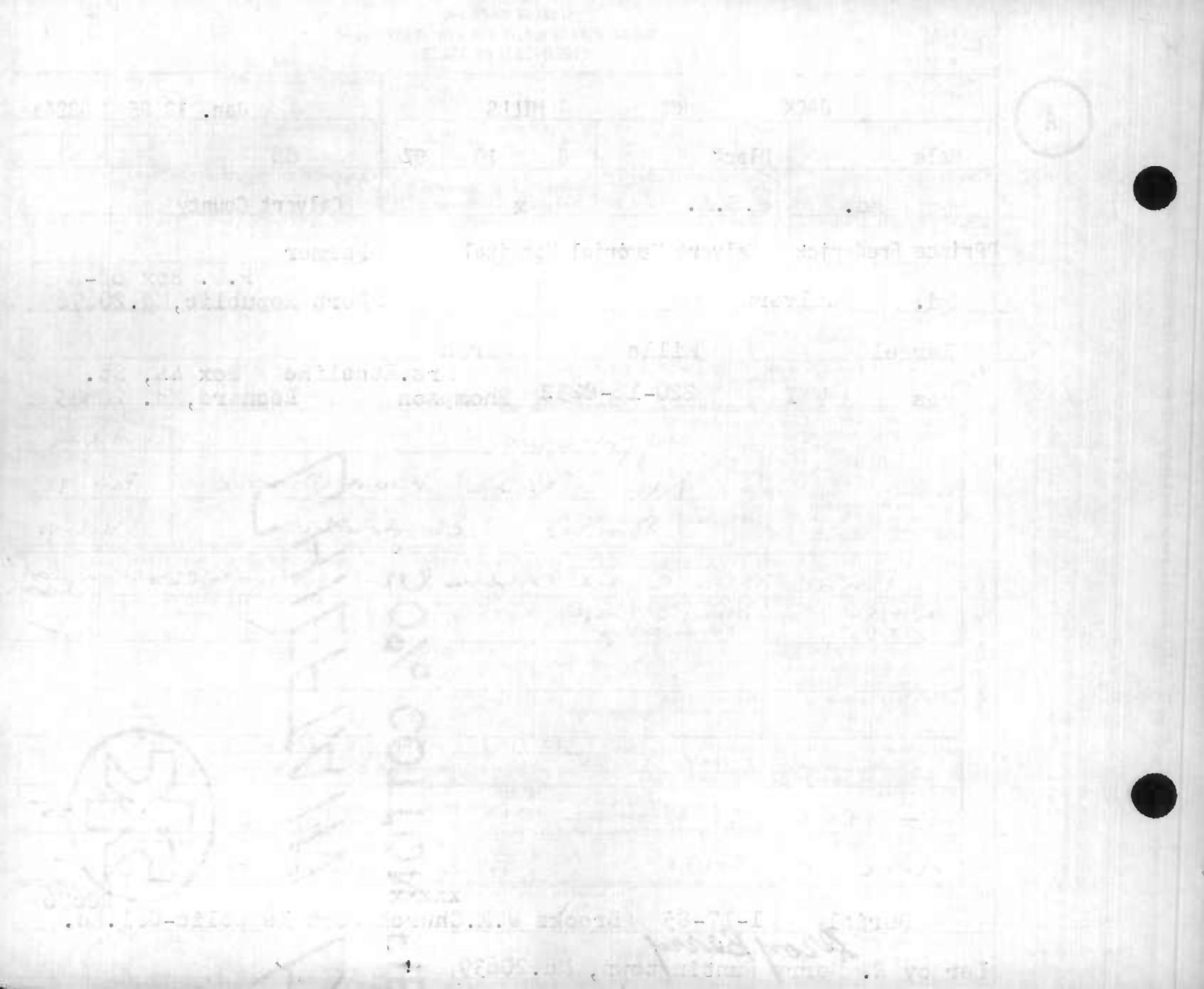
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501750
1 - STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
A JACK NMN MILLS			Jan. 13 85			0324a m				
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 6 DAY 10 YEAR 96	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Calvert County			MD.				
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.	13b. COUNTY Calvert	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P.O. Box 68-A Port Republic, Md. 20676				
14. FATHER'S NAME FIRST Israel	MIDDLE	LAST Mills	15. MOTHER'S MAIDEN NAME Sarah			16. SOCIAL SECURITY NO. 220-16-8232				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. INFORMANT Mrs. Etheline Thompson	17. ADDRESS Box 44, St. Leonard, Md. 20685	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u> Few yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) <u>Possible Dehydration</u> 4 days			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Possible sepsis, Severe Organic Brain Syndrome, Cerebrovascular disease</u>										
19a. DATE OF OPERATION 12/18/84 1/7/85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1 st and 2 nd degree Burns - Gastrectomy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/15/1984 to 1/13/1985, that (I) (we) last saw the deceased alive on 1/12/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Atul R. Shah</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/13/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Atul R. Shah	22e. ADDRESS Calvert Memorial Hospital Prince Frederick, Md. 20678									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-17-85	23c. NAME OF CEMETERY OR ADDRESS Brooks U.M. Church	23d. LOCATION CITY OR TOWN Port Republic-Cal. Md.	20676						
24. FUNERAL DIRECTOR NAME Leroy E. Berry	ADDRESS Berry Huntington, Md. 20639	25a. DATE REC'D. BY REGISTRAR 1/17/85	25b. REGISTRAR'S SIGNATURE <u>Atul R. Shah</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8501751	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Lillian Elizabeth NEWMAN						January 27, 1985			11:50a		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE		WHITE		Oct. 24 1919			65				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD	
VIRGINIA		U.S. A.					Calvert				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Prince Frederick		Calvert Memorial Hospital								CORRECTION OFFICER GOVERNMENT	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS	
Maryland		Calvert		Huntingtown			Rt. 1 Box 67 Holland Cliff Rd.			20639	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
William		Thelma Ford									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		266-16-3617		NANCY DWYER			SAME AS #13 ABOVE			12 DAYS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										BRONCHOPNEUMONIA	
DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED CARCINOMA (SQUAMOUS) DUE TO, OR AS A CONSEQUENCE OF (c) (R) LUNG CELLS										FEW MONTHS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Abcesses (R) upper lobe (LUNG) (S) P lymphoma											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11/15 1985 to 11/27 1985, that (I) (we) last saw the deceased alive on 11/27 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 1/28/85	
22b. SIGNATURE A T Munshi		DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			Prince Frederick, Maryland 20678						
Anwar T. Munshi, M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN GLEN ALLEN COUNTY HANOVER STATE Va				
Burial		JAN 30 '85		Calvary Christian							
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR/REGISTRAR'S SIGNATURE JAN 31 1985 Julia Davidson-Randall						
Rausch		OWINGES MD									



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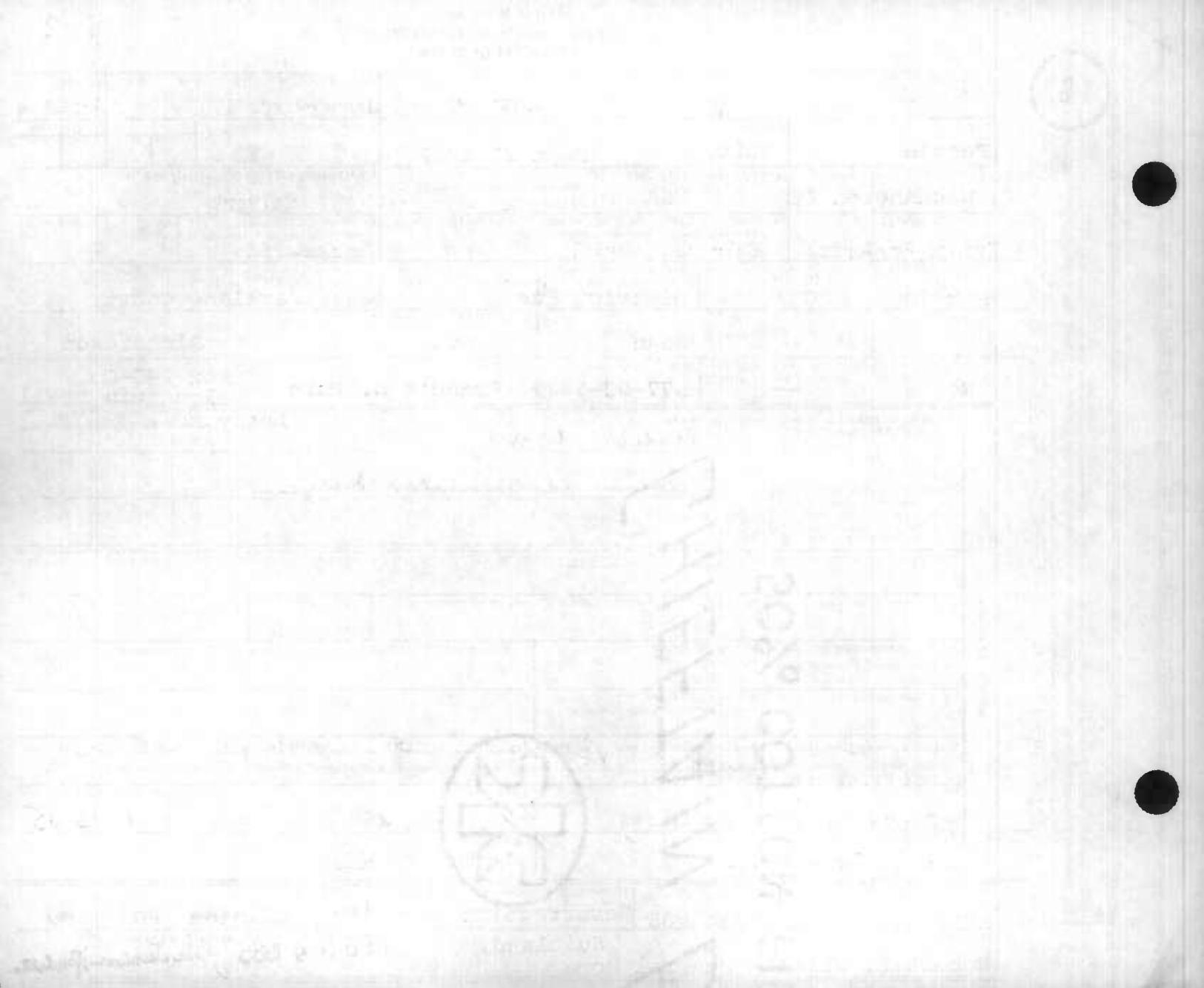
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified and the death certificate should be held for further examination.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8501752							
												REG. NO.							
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
Emma R			PETERSON			January 26, 1985			4:26A M										
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Sept 27 1902			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE COUNTRY Washington DC			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert			MD							
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			--							
13a. STATE Maryland			13b. COUNTY PG			13c. CITY OR TOWN District Hts			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 6029 Parkland Court							
14. FATHER'S NAME FIRST MIDDLE LAST Bean			15. MOTHER'S MAIDEN NAME FIRST Eva			16. ADDRESS Lusby, Md			17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			Richardson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577-03-5429			17. INFORMANT Francis E. Ruth			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>										
19. MEDICAL CERTIFICATION 99			20. CONDITIONS DUE TO, OR AS A CONSEQUENCE OF (b) <i>Stroke Cardiovascular Disease</i>			21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.			22. DATE OF OPERATION			23. CONDITION FOR WHICH OPERATION WAS PERFORMED			24. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
																		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			21h. COUNTY			21i. STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>January 10 1985</i> to <i>January 26 1985</i> , that (I) (we) last saw the deceased alive on <i>January 25 1985</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <i>Ronald E. Thomas, M.D.</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1-26-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 29 Jan 1985			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton			23e. COUNTY PG			23f. STATE Md				
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home			25. ADDRESS Suitland, Md			25a. DATE REC'D. BY REGISTRAR/SD. REGISTRAR'S SIGNATURE FEB 04 1985													
DHMH - 16 50M 4/82 (VRA 15, 4)												Julie Davidson-Pender							



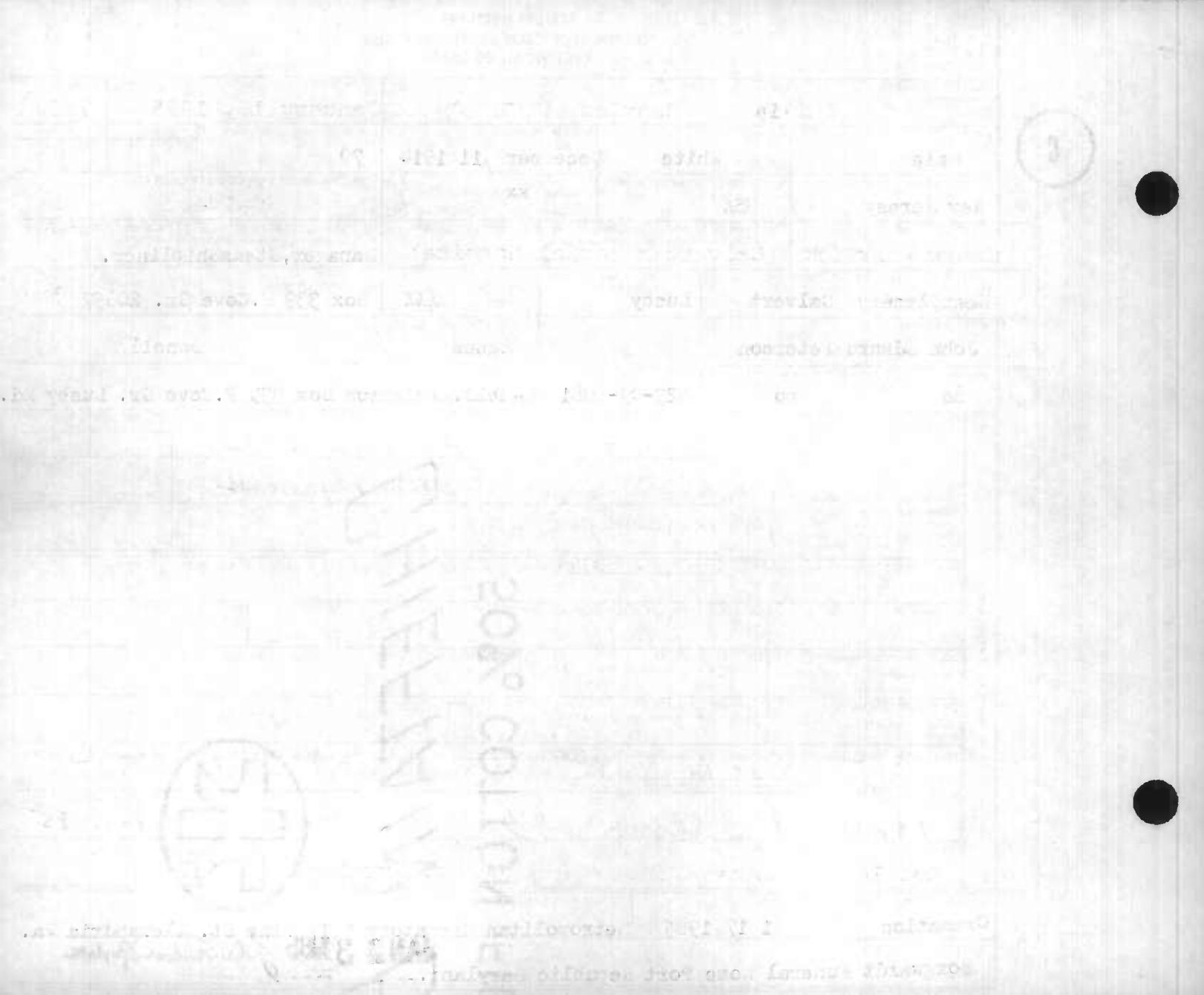
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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and examined.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 7 5 3					
										REG. NO.					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Philip Charles PETERSON									January 15, 1985				7:50 A M
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White			MONTH December DAY 11 YEAR 1914			70			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Calvert MD.				
New Jersey		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Prince Frederick		Calvert Memorial Hospital						Manager, SteamShip liner.							
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Lusby		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		Box 339 F. Cove Dr. 20657				
14. FATHER'S NAME John Edward Peterson		15. MOTHER'S MAIDEN NAME Agnes									Danell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. no			17. INFORMANT			ADDRESS							
no		059-09-8081			Ruth S. Peterson			Box 339 F. Cove Dr. Lusby Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of prostate with bone metastasis</i>															
DUE TO, OR AS A CONSEQUENCE OF (b) _____															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>November 19 81</i> to <i>January 19 85</i> , that <input type="checkbox"/> (we) <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <i>1-14 85</i> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input type="checkbox"/> (we) <input type="checkbox"/> (did) (did not) view the body after death.															
22b. SIGNATURE <i>Ronald E. Thomas</i>		DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-15-85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			Lusby, Maryland 20657							
Ronald E. Thomas, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1 17 1985			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN 5512 Vine St. Alexandria Va.			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Borgwardt Funeral Home Port Republic Maryland															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 0 1 7 5 5 CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Frances VIAR SPENCER						Jan. 26 1985			4:15a M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		April 18, 1923		61 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Virginia		U.S.A.				Calvert County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Prince Frederick		Calvert Memorial Hospital		Bookkeeper			Enesco Company			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Maryland		Calvert		St. Lenards					P.O. Box 266	
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME						
Olaf		L. Viar		Lela			NMN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
No		223-22-7522		Henry A. Via			P.O. Box 266 St. Leonards Maryland 20685			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio pulmonary arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>my cardiac infarction</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>emphysema</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>emphysema</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (1) (his hospital) attended the deceased from 1-25, 19 85, to 1-26, 19 85, that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Ronald J. Ross</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ronald J. Ross MD</i>		22d. ADDRESS <i>Prince Frederick MD</i>						22e. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Jan. 29, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Mount Comfort		23d. LOCATION CITY OR TOWN Alex.		COUNTY STATE Fairfax Co., Va.		
24. FUNERAL DIRECTOR NAME <i>D. Cunningham</i>		ADDRESS CUNNINGHAM Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR JAN 30 1985		25b. REGISTRAR'S SIGNATURE <i>John Cunningham</i>				

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Calaveras County

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San Joaquin Library

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										01 / 56										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF ESTI- MATED DEATH	2b. HOUR							
TRICIA			LEE			STEPHENS						XX 1-2-85 19	M							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS	MONTHS	DAYS	HOURS	MIN				2c. DATE PRONOUNCED DEAD	2d. HOUR						
Female	White	May 1, 1970	14 yrs.										1-6-85	12N M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> XX WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Calvert County			Sunderland		Rt. 2&Rt. 4 Thompson's Saw Mill Property		Student		9th Grade			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
Maryland		Calvert Co.		Pr. Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Star Rt. #1 Box 40A1 20678		John P. Stephens		Yvonne Courtney								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT John P. Stephens Same as # 13-A-E			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Blunt force injuries and strangulation			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
												DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.								
												(b) DUE TO, OR AS A CONSEQUENCE OF								
												(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?								
															YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. PLACE OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
			10:40AM 1-6-85			subject assaulted														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
			saw mill property			Rt. 2&Rt. 4			Sunderland			Maryland								
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> and in my opinion			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 1-7-85								
EXAMINER'S NAME (TYPE OR PRINT)			111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1-10-1985			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection			23d. LOCATION CITY OR TOWN			COUNTY			STATE					
Burial																				
24. FUNERAL DIRECTOR NAME			Lee Funeral Home Inc.			ADDRESS			25a. DATE 1-10-1985			25b. REGISTRAR'S SIGNATURE <i>Clinton</i>								
6633			Old Alexander Ferry Rd., Clinton, Maryland 20735																	

A



1960-1961

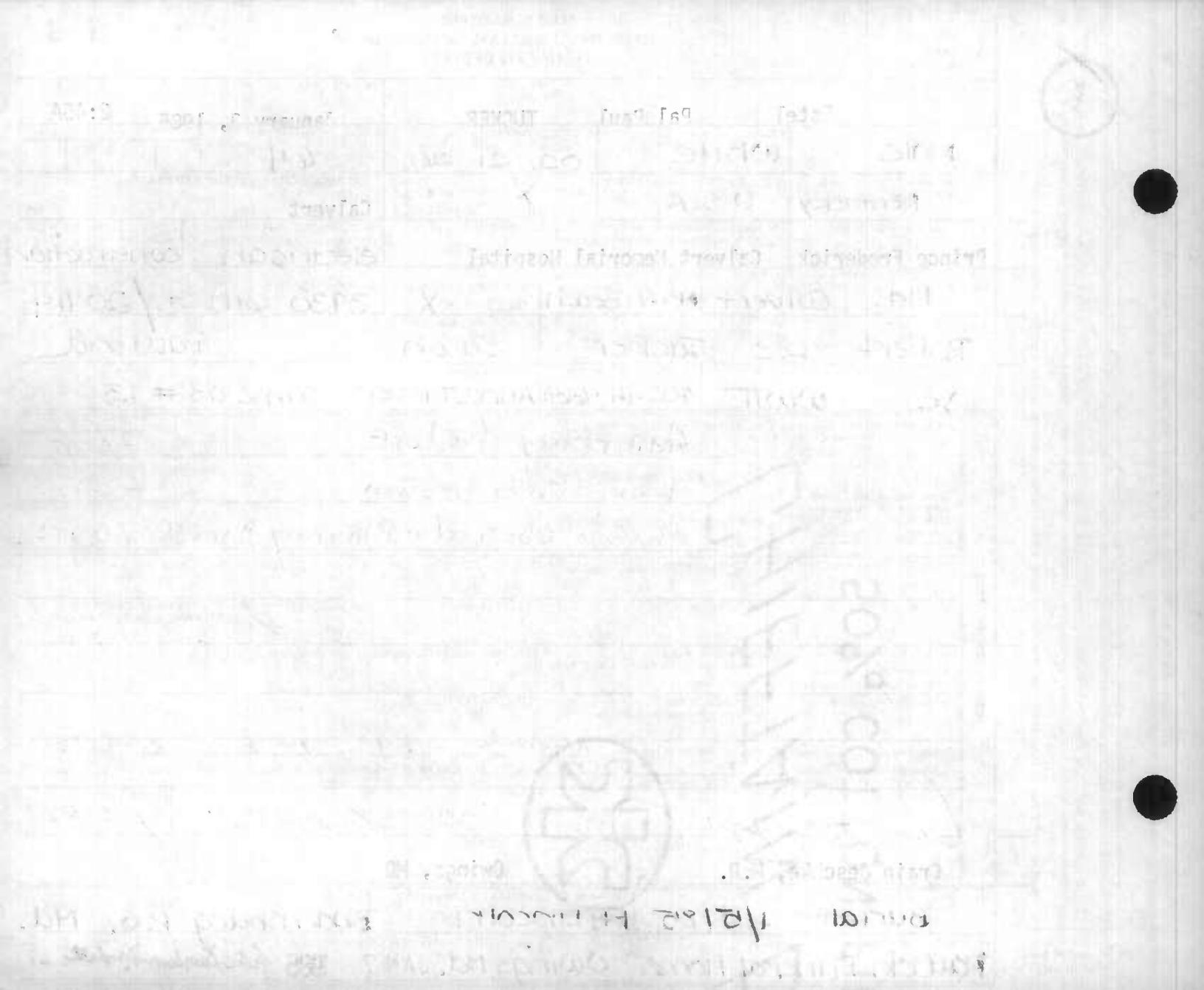
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if there is any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 5 0 1 7 5 8				
					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Estel		Paul	TUCKER	January 3, 1985				2:45A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
Male	white	MONTH 02 DAY 21 YEAR 20	64	MONTHS	YEARS	MONTHS	YEARS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Kentucky	U.S.A.		Calvert						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Prince Frederick	Calvert Memorial Hospital					electrician			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	12b. KIND OF BUSINESS OR INDUSTRY				
Md.	Calvert	North Beach		3930 6th St. / 20714	construction				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST		
Robert	Lee		Tucker	Sarah			Paulina		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS						
yes	402-14-6691	Anna Tucker	same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure									
DUE TO, OR AS A CONSEQUENCE OF (b) Lung Carcinoma									
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease 10 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>November 19 84</u> to <u>1-2 19 85</u> that (I) (we) last saw the deceased alive on <u>1-2 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Craig Jeschke, M.D.				Owings, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	23e. COUNTY					
Burial	1/5/85	Ft. Lincoln	Bladensburg P.G.	Md. STATE					
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE		
Rausch Funeral Home	Owings, Md.	JAN 7 1985					Julia Davidson-Vendell		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical Examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 1 7 5 9					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
James A. TRIGGER									January 7, 1985						8pm M		
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
						Sept. 15, 1902			89			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert County			MD.					
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) electrician			12b. KIND OF BUSINESS OR INDUSTRY private indust								
13a. STATE Maryland			13b. COUNTY Calvert			13c. CITY OR TOWN Broomes Island			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Oyster House Road 20615					
14. FATHER'S NAME FIRST MIDDLE LAST Ashley Trigger									15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret			unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 579 03 2128			17. INFORMANT Robert R. Trigger same as above			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
									b) Chronic obstructive lung disease								
									c) Chronic congestive heart failure								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Emad Albanna, M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Emad Albanna, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 10, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem. Park			23d. LOCATION CITY OR TOWN Catonsville, Maryland			COUNTY STATE					
24. FUNERAL DIRECTOR Donaldson Funeral Home, Laurel, Md.									25a. DATE RECORD IS MADE JAN 1 1985								



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PAINTED GOLD

COTONVILLE, MARY.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the death certificate and placed in the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 7 6 0			
										REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			WILLIAM M WELLS						1/13/85			8:35 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
M			W			2 6 1890			94			YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			USA						Calvert				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Prince Frederick			Calvert Nursing Center						Former			Tobacco	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Maryland			Calvert			Owings						225 Briscoe Turn Rd 20736	
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT	
John			D Wells			Agnes			2166340044			David Wells son of #13	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. SOCIAL SECURITY NO.			18c. ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes			18c. ADDRESS										
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)													
(b) METASTIC CARCINOMA - UNKNOWN PRIMARY													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from FEB 19 83 to JAN 13 19 85, that (I) (we) last saw the deceased alive on 12/31 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.													
22b. SIGNATURE JOHN H. WEIBER										22c. DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN H. WEIBER										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1/13/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1-15-85			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN Owings Calvert			COUNTY STATE	
24. FUNERAL DIRECTOR Rausch Funeral Home			ADDRESS			Owings Maryland			25a. DATE REC'D. BY REGISTRAR 20736 JAN 17 1985			25b. REGISTRAR'S SIGNATURE John Davidson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ³ it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 5 01761							
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 16. HOUR														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			January 13, 1985 8:35pm											
Albert Wright ZAHNISER																	
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
					November 1, 1907			77									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert									
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
			Calvert Memorial Hospital		Marina & Boatyard Owner.												
13a. STATE Maryland			13b. COUNTY Calvert		13c. CITY OR TOWN Solomons			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 146 Solomons Maryland		206883					
14. FATHER'S NAME FIRST Albert			MIDDLE Wright		LAST Zahniser (D)			15. MOTHER'S MAIDEN NAME FIRST Hannah		MIDDLE Oliver		LAST Barton (D)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NO		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>sympathetic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute renal failure & massive UGI bleed</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. MEDICAL CERTIFICATION			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>1-13</u> <u>July</u> , 19 <u>82</u> , to <u>January</u> , 19 <u>85</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>1-13</u> 19 <u>85</u> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.			22b. SIGNATURE <u>Ronald E. Thomas, M.D.</u> DEGREE										22c. DATE SIGNED 1-14-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							22e. ADDRESS Lusby, MD 20657							
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 19 16-85		23c. NAME OF CEMETERY OR CREMATORIAL St. Peters Cemetery			23d. LOCATION CITY OR TOWN Lusby		COUNTY Calvert		STATE Maryland					
24. FUNERAL DIRECTOR NAME Borgwardt Funeral Home Box 34 B Post Republic			25a. DATE REC'D. BY REGISTRAR JAN 23 1985										25b. REGISTRAR'S SIGNATURE Julia Davidson-Pender				

